CHAPTER 3: Program Components

Policy: Standards of casework will be provided to all sites to ensure compliance with the federal Home- and Community-Based Services Waiver.

Purpose: This chapter provides information on the components of the Multipurpose Senior Services Program Branch (MSSP) care management process from outreach and initial screening to termination of program participation. Program standards reflect the following assurances made to the Centers for Medicare & Medicaid Services (CMS).

- MSSP sites must certify and report to the California Department of Aging (CDA) that care management staff meet prescribed qualifications.

- At the time of enrollment the client is informed of their

    - Rights to a State Fair Hearing process.
    - Rights to freedom of choice between waiver services and institutional care.
    - Rights to freedom of choice among service providers.

- The initial LOC determination must be completed within 30 days of MSSP application. (Section 3.410). The LOC may be concurrent with the application and is a requirement for enrollment.

- The Level of Care (LOC) determination must be made by the MSSP Nurse Care Manager (NCM) on an MSSP approved form, consistent with the need for institutionalization per the California Code of Regulations, Title 22, Sections 51334 and 51335.

- LOC re-certifications must be completed within 365 days of the previous LOC.

- Care plans are based on MSSP approved assessment tools and include services that fully address the needs and goals.

- Clients must be involved in the care plan process and indicate their agreement by signing the care plan.

- Care plans must be revised at least annually and as client needs change.

- Services/interventions delivered to the client must match the care plan, service code and be paid appropriately.

- Only vendors who meet qualifications and licensure requirements can provide services for waiver participants.

- Care Management staff monitor clients by monthly telephone contact, quarterly face-to-face home visits and annual reassessments, at a minimum.

- As mandated reporters, MSSP site staff must report all critical incidents of client abuse, neglect and exploitation, including self-neglect, to the appropriate local agency. Information regarding any incident and outcome that the care manager is aware of must be documented in the progress notes and reported on the Quarterly Report submitted to CDA.

- CDA MSSP Branch will perform utilization reviews on MSSP sites.

- CDA Audits Branch will perform financial audits on MSSP sites.

- Assurances to CMS also provide that each client is Medi-Cal eligible at enrollment and throughout program participation; and that all waiver and care management services are appropriate and necessary.

References:

- Home-and Community-Based Services Waiver #0141.R04.00.
- Interagency Agreement between DHCS and CDA.
- CDA Standard Agreement (Site Contract).
- California Code of Regulations, Title 22, Sections 51334 and 51335.

3.000 Outreach

Outreach and case finding efforts are to be specific to each site's situation. A new MSSP site conducts outreach to inform the community of its existence and services; sources of referrals to the program are sought; and working relationships are initiated. As the site becomes established, outreach and case finding activities continue, but their nature evolves and changes.

Changes in State MSSP policies and the site's own host agency require that the MSSP site continually redefine itself within its community. It is important for site administration to assume control of this process with a proactive approach based on a well-defined outreach plan. This will ensure appropriate referrals of applicants to the program, and clarify where MSSP fits in the context of services offered in the community.

3.010 Ongoing Outreach Efforts

Each MSSP site will engage in ongoing client outreach and case finding efforts. Outreach and case finding may require ongoing interaction with a variety of community entities such as:

- Discharge planners in acute care hospitals and long-term care facilities.
- County-based In-Home Supportive Services programs.
- Medi-Cal Field Office staff.
- Home health agencies, social services agencies, physicians, other health and community providers.
- Potential clients and their families.

3.020 Waiting Lists

There will be times when referrals cannot be accommodated on a flow basis and a waiting list will be established. Each site will develop a formal policy for management of referrals awaiting enrollment decisions. Elements for consideration in this policy include, but are not limited to, how the waiting list will be prioritized (e.g., acuity of need, time on the list), and follow-up with those pending enrollment (e.g., frequency and person responsible).

3.020.1 Wait List Data

Wait list data regarding the number of individuals on the list and the average length of time on the list will be maintained and reported to CDA on the Quarterly Report.

3.030 Standards

The CDA/MSSP policy for client monitoring and follow-up is as follows:

- All new MSSP clients must receive initial face-to-face home visit assessments by both the SWCM and the NCM.

- All clients must be monitored monthly by a member of the care management team. Monitoring entails review of each care plan problem statement and evaluating the effectiveness of the care plan through face-to-face or telephone contact. The preferred contact is between the care manager and the client. If it is necessary to

communicate with another party (e.g., support person or caregiver), the reason should be stated.

- A face-to-face visit with each client by a member of the care management team must be conducted quarterly (at 3 month intervals) in the client's residence. In the event that extenuating circumstances exist and the visit cannot be conducted in the client's home, the reason must be documented in the progress notes.

- A face-to-face home visit with each client by either the SWCM or NCM is required for the reassessment (Section 3.630, Reassessment) each year.

- A face to face home visit conducted by the alternate discipline is required each year. The alternate discipline visit should occur at 12 month intervals and may be linked to a Quarterly home visit or the Reassessment.

3.040 Sequence of Care Management Processes

The sequence of events is as follows:

1. Pre-Screening.
2. Screening.
3. Application.
4. Certification (level of care).
5. Enrollment date (when all client eligibility criteria is satisfied).
6. Client Enrollment/Termination Information Form.
7. Assessment.

These activities may occur on the same date.

3.100 Eligibility

There are certain eligibility criteria that must be met in order to receive services as a client of MSSP. Eligibility for the program is addressed initially at pre-screening and/or screening, and confirmed throughout participation in the program.

The MSSP eligibility criteria include all of the following:

- Certifiable for placement in a nursing facility (NF) (Section 3.110 Certifiable for Placement in a Nursing Facility) also known as "level of care", per California Code of Regulations, Title 22, Sections 51334 and 51335 (Appendix 15).
- Age 65 or older (Section 3.120, Age 65 and Older).
- Receiving Medi-Cal under an appropriate aid code (Section 3.130, Receiving Medi-Cal under an Appropriate Aid Code).
- Able to be served within MSSP's cost limitations (Section 3.150, Able to be served within MSSP's Cost Limitations).
- Appropriate for care management services (Section 3.160, Appropriate for Care Management Services).

3.110 Certifiable for Placement in a Nursing Facility (or Level of Care Determination)

General Criteria:

An individual evaluation for the required LOC per California Code of Regulations, Title 22, Sections 51334 and 51335 must be made for each eligible applicant. General criteria include:

- LOC determinations must be documented on the Level of Care Certification form (Appendix 16) which is available electronically. All certifications, including initial and re-certifications, must be recorded on this form by a nurse care manager (NCM).

- NCM's must date and sign the LOCs (Section 5.810, Staff Signatures and Signature Requirements).

- The client's case record must contain supporting information (e.g., assessment information, physician or other consultant information) that substantiates the LOC determination.

3.110.1 Clinical Judgment

LOC determination is a clinical judgment made by the NCM in accordance with the California Code of Regulations, Title 22, Sections 51334 and 51335. The initial LOC certification is completed after the application is signed by the client and before enrollment occurs (Section 3.040, Sequence of Care Management Processes).

LOC determinations are based on the nurse's professional assessment and observations and/or information gathered through the screening tool and other sources such as care management staff, the client, the attending physician and others involved in caring for the client. The information required for this analysis may be obtained by conducting a home visit, by a record review, or by a combination of both activities.

3.110.2 Use of the California Code of Regulations (CCR), Title 22, to Determine Eligibility

The applicant must be certified as functionally impaired or have a medical condition to the extent of requiring the LOC provided in a nursing facility (NF).

The LOC standards for NF are set forth in the California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 4, Sections 51334 and 51335. The complete regulations are located in Appendix 15.

3.110.3 Application of Title 22 Criteria

The Title 22 criteria (Appendix 15) were developed specifically for NF eligibility, thus, applying these criteria to determine LOC for individuals living in the community can be challenging. To make this translation from facility or "patient-focused" to community-based or "client-focused" care, the NCM must focus their analyses and judgment on the following elements:

- Cognition and/or Sensory deficits: At the minimum, the client's mental status i.e., whether the client is alert and oriented to person, place, time (X3); oriented to person only; confused; nonverbal secondary to diagnoses of late-stage dementia. Additional cognitive status (x4) describing situation may be included.

  Example 1:
  - Client is alert and oriented to person, place and time.

  Example 2:
  - Client with late stage dementia is oriented to person only and requires around the clock supervision.

- Activities of Daily Living (ADLs).

  Example:
  - Client has difficulty performing grooming and bathing d/t chronic pain from osteoarthritis and herniated disc, requires hands-on assistance for both.

- Instrumental Activities of Daily Living (IADLs).

  Example 1:
  - Client self-administers medications, but is non-compliant with physician's orders for medications.

Example 2:
- Client requires wheelchair for mobility outdoors due to obesity and end-stage Chronic Obstructive Pulmonary Disease (COPD).

Example 3:
- Unable to ambulate without walker due to left leg weakness secondary to Cerebral Vascular Accident (CVA).

Example 4: (ADL/IADLs combined):
- Requires stand-by assistance for stair climbing, hands-on assistance with bathing and outdoor mobility. Uses walker for indoor mobility. Caregiver fills weekly medication dispenser, client able to take medications independently each day. Dependent for chore, errands, meal preparation. Independent for all other ADL/IADLs.

- Other/Environment (e.g., bed-bound clients, client who cannot be safely left alone).

Example:
- Due to CVA resulting in paralysis, client is bed-bound and requires around-the-clock care and supervision.

3.110.4 (Section Retired)

3.110.5 Completion of LOC Certification Sheet (Appendix 16)

The LOC certification form (Appendix 16) must be completed to certify the **LOC requirement**. This validates that the client has functional deficits that meet the eligibility criteria "certifiable for placement in a nursing facility." All certifications must be recorded on this form. Forms must be fully signed and dated by the NCM. (Section 5.810, Staff Signatures and Signature Requirements).

The NCM will indicate the source of the information on the form (client visit or record review).

Source of Information: ☐Client Visit or ☐Record Review

The rationale and justification for the LOC determination must be summarized by the NCM in the space provided. At a minimum, the areas of functional deficit to be addressed and recorded on the LOC form are:
- Cognitive and/or sensory deficit
- ADLs
- IADLs

Documentation must identify functional deficits and limitations not simply list medical diagnoses. **Note:** The client's case record must contain supporting documentation or evidence that substantiates the client's LOC.

Examples of LOC statements:

Example 1:

- Client has mild dementia but is able to report changes in health. Ambulates independently indoors, requires stand-by assistance with stairs and outdoor mobility. Needs stand-by assistance with bathing and dressing. Independent for eating, transferring, toileting and grooming. Needs total assistance with all IADLs except telephone use, some meal preparation and money management. Able to heat meals in microwave. Client is able to self-administer medications that caregiver refills and places in medi-set weekly.

Example 2:

- Client is oriented to person and place and is hard of hearing. Due to poor endurance secondary to CHF, client needs hands-on assistance for safe transfers and cannot climb stairs. Uses wheelchair for outdoor mobility. Ambulates independently indoors using a four-wheeled walker. Requires medication management from caregiver due to short-term memory loss. Requires hands-on assistance for all ADLs. If caregiver prepares meal set up client can feed self. Client needs total assistance for all IADLs except can use California Telephone Access Program (CTAP).

3.110.6 Recertification (Reevaluation) for LOC

The purpose of the recertification review is to verify that the client continues to meet the LOC requirements for MSSP participation. Recertification is **required** at 365 day intervals from the date of the last LOC, or more frequently if the client's status has changed.

3.120 Age 65 or Older

Age is to be verified by checking the date of birth on the Medi-Cal card. If an applicant presents conflicting documentation from any other source (i.e., immigration forms), information on Medi-Cal documents prevails.

3.130 Receiving Medi-Cal under an Appropriate Aid Code

In order to be eligible for MSSP, the client must have a qualifying primary Medi-Cal aid code. Qualifying primary Medi-Cal aid codes are: 1D, 2D, 6D, 1E, 2E, 6E, 1X, 1Y, 10, 14, 16, 1H, 20, 24, 26, 60, 64, 66, and 6H. These codes are further defined in Appendix 7.

Applicants for MSSP who appear eligible for Medi-Cal but are not receiving benefits should be referred to the county welfare department for Medi-Cal eligibility determination, utilizing institutional deeming, if appropriate (Section 3.130.1, Institutional Deeming).

MSSP sites are only required to service clients with aid codes 17, 27, or 67 who were active as of November 1, 2005 or were subsequently re-determined into 17, 27, or 67.

Verification of initial and continuing client eligibility for Medi-Cal is each site's responsibility. Sites should verify Medi-Cal eligibility monthly. Batch eligibility verification is available through the Medi-Cal website at: www.medi-cal.ca.gov.

Sites that do not verify each client's Medi-Cal eligibility could be at risk for non-payment.

3.130.1 Institutional Deeming (MSSP Aid Codes 1X and 1Y)

There are two ways of considering or "deeming" an individual's income and assets when they apply for Medi-Cal, depending on where they live: in an institution or in the community. According to the California Department of Social Services Manual of Policies and Procedures, Chapter 30-701 (d) (1), "Deeming means procedures by which the income and resources of certain relatives, living in the same household as the recipient, are determined to be available to the recipient for the purposes of establishing eligibility and share of cost."

In determining Medi-Cal eligibility for someone living in an institution (institutional deeming), the income or resources of a parent or spouse are not considered as being available to that individual. Instead, the institutionalized person is considered to be an isolated unit in terms of budgeting, even though they may be someone's minor child or spouse. The income and assets available to the institutionalized person are "deemed" to belong to the other family members, up to certain limits. In determining Medi-Cal eligibility for someone living in the community other standards apply. The family is typically considered to be one budget unit for purposes of accounting for assets and resources (community deeming). Since MSSP clients meet nursing facility (NF) level of care requirements, Medi-Cal eligibility rules for institutionalized individuals (institutional deeming) can be applied. The result may be that by deeming assets and resources to a spouse (resulting in those assets not being considered in a person's Medi-Cal application), some individuals may then be eligible for Medi-Cal benefits, including the MSSP waiver.

While Medi-Cal eligibility is a requirement for MSSP, institutional deeming is not necessarily the answer for all potential MSSP clients because of the impact on their eligibility for either the Personal Care Services Program (PCSP) or IHSS provided under the State Plan (formerly IHSS Plus Waiver). One important difference is that under PCSP, the client's spouse (or parent, if the client is a minor child) cannot be paid as the provider of personal care services (Welfare and Institutions Code, Section 14132.95 [f]), nor may services be provided under advance pay status. Some potential MSSP clients who have their spouse as their provider or who receive advance pay may be unable or unwilling to change these arrangements.

IHSS provided under the State Plan and PCSP also differ in their treatment of income and assets. IHSS under the State Plan looks at the income and resources of the parent or spouse when determining eligibility. Therefore institutional deeming procedures cannot be applied. The result is that institutional deeming is appropriate only for those who are eligible for PCSP.

Referrals for institutional deeming will be made by sending the CDA Waiver Referral form (MC 364) (Appendix 8) directly from the site to the local county welfare office. This form is available online through two sites:

1. By Medi-Cal program form number (MC 364)

http://www.dhcs.ca.gov/formsandpubs/forms/Pages/MCEBbyNumber.aspx

2. By Medi-Cal program form name:

http://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc364.pdf

Each MSSP site will designate one person (and a back-up) to coordinate referrals and act as liaison with designated staff at the county.

MSSP staff must determine that an applicant meets all waiver eligibility criteria (with the exception of Medi-Cal eligibility) before referring the individual to the local county welfare office to have their application for Medi-Cal processed. This eligibility determination includes an initial LOC certification.

Applicants should be informed that they will be receiving an application packet for Medi-Cal from the county. It is very important that these forms be completed and returned to the county in a timely manner. Once the Medi-Cal application has been processed and eligibility confirmed, the applicant may be enrolled in MSSP.

Institutionally deemed clients are limited to five percent (5%) of a site's total caseload. It is important to track the information regarding the number of clients utilizing institutional deeming in order to assure that this limitation is not exceeded.

Two Medi-Cal aid codes have been established for those applicants who qualify under this institutional deeming provision: 1X (those with no share of cost), and 1Y (those with a share of cost).

It is important that clients who become eligible for Medi-Cal via institutional deeming understand that continuing eligibility for Medi-Cal is conditional upon continuing eligibility for the MSSP waiver. Therefore, if they are terminated from MSSP, they also lose their other Medi-Cal benefits. A special application form containing this information (Appendix 10) will be used to enroll these individuals. There is also a specific section on the termination letter (Appendix 2) that addresses the linkage between MSSP and Medi-Cal for these clients.

3.140 Residence within the Site's Contracted Service Area as Defined in the Site's Contract

ZIP Codes for client residences should be within the geographic boundaries defined in the site's contract. Requests to change a site's contracted service area must be approved by CDA prior to serving clients outside the contracted service area.

3.150 Able to be served Within MSSP's Cost Limitations

Each MSSP site's average monthly cost for all Title XIX services cannot exceed 95% of the average monthly cost of institutional care (Section 3.920, Benchmark and Appendix 33). During the screening process, if ongoing costs are projected to exceed the cost of institutional care (100% of the Benchmark), the applicant is ineligible for MSSP. However, if there is a definite plan to bring these costs down to the Benchmark within three months, the applicant may be enrolled (Section 3.920, The 'Benchmark' and Calculation of Client Costs, and Section 3.930, Authorization and Utilization of Services).

3.160 Appropriate for Care Management Services

This criteria addresses the client's need for and ability/willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a client requires assistance to: gain access to community services; maintain or effectively utilize available services; and/or manage serious health conditions.

- "Ability/willingness to participate" is indicated by the client's cooperation in formulating and then carrying out the care plan.

Note: The term "client" includes a client's Personal Representative when the client is cognitively unable to participate independently. (Section 3.520, Authorization for Use and Disclosure of Protected Health Information Form).

It is important to confirm and document a new client's perception of why they were referred to the program, and how they characterize their situation, needs and goals. This would logically occur during either the screening or the assessment process. Differences in perceptions between the referral source, the client, and the care manager must be identified, acknowledged and addressed in the initial assessments. Changes in these issues should be acknowledged and recorded in the progress notes. The Reassessment Summary (Appendix 20) includes areas to record "Client Concerns" (What the client and family want from MSSP) and "Indications for Care Management."

3.200 Pre-Screening

Potential clients are pre-screened to determine eligibility and appropriate-ness for participation in MSSP.

3.210 Screening Forms

Screening forms or tools may vary from site to site; however, each site must be consistent in the form and process it employs. The screening form must be completed for every referral. If an applicant is deemed ineligible, the screening form must be retained in a separate file for seven (7) years from the date of the decision. (Section 3.230, Referrals not Accepted for MSSP Participation).

3.220 The Screening Process

The initial screening can be performed by telephone or in person, at a community agency, at the person's place of residence, or in an acute care hospital or nursing facility. If the screening is conducted in an institution, the person may not be enrolled in the program and no services can be provided until s/he is discharged from the facility and residing in the community, except as permitted under Deinstitutional Care Management (Section 3.1300).

Written notice is **not** required if someone chooses not to participate, or does **not** meet the criteria for age, Medi-Cal eligibility, or residence. The MSSP staff conducting the screen will inform them they may contact the program at a later date should their situation change. Site staff should attempt to link ineligible applicants to other community resources.

For those applicants enrolled in MSSP, the screening form must be completed and retained in the client record.

3.230 Referrals not Accepted for MSSP Participation

Medi-Cal beneficiaries who live in the site's contracted service area who are age 65, but do not meet other MSSP requirements but still wish to participate, must receive a written notice regarding their right to a State Medi-Cal hearing in accordance with Welfare and Institutions Code, Sections 10950-67 (Appendix 1). Disqualified applicants must receive a written notice (Notice of Action, NOA) stating the reason for this decision (Appendix 2), including instructions for requesting a fair hearing (Appendix 5).

All records of applicants not accepted for MSSP participation must be retained by the site for state and federal review for a period of seven years from the date of the decision (Chapter 6, Client Rights).

3.300 Application for MSSP Services

3.310 Non-enrolled Persons

Persons who pass the initial pre-screening process and require further assessment to determine eligibility, but are not accepted for MSSP participation are given a written notice (Appendix 2) and have the right to a State Medi-Cal hearing (Appendix 5) in accordance with Welfare and Institutions Code, Sections 10950-67 (Appendix 1). All records of persons not accepted for MSSP participation must be retained by the site for state and federal review for a period of seven years from the date of application (Chapter 6, Client Rights).

3.320 Freedom of Choice

Persons deemed eligible for participation in MSSP will be informed of their right to choose whether they will participate in MSSP. Potential applicants must be informed of the following:

- The right to refuse services.
- The right to choose institutional care (NF).
- The right to choose a specific care management provider.
- The right to choose a specific service vendor.

3.330 Application

The Application (Appendix 9) is used to apply for services. It summarizes what the client can expect from the program, alternatives regarding services, and the rights of program participants.

The application must be completed for all persons interested in participating in MSSP. A copy of the form must be provided to the client. The original signed application must be retained in the client's record.

If the client is unable to sign for themselves, the following individuals may sign for them:

1. Conservator. This is a person appointed by a court.

2. Agent. This is a person named in the client's power of attorney for health care.

3. Personal representative. This is an adult designated by the client, either in writing or orally, in the presence of a MSSP care manager.

If a client is not able to fully sign their name, an "X" is acceptable.

3.400 Enrollment

3.410 Sequence of Enrollment Activities

Within 30 days of the application for participation in MSSP, the LOC determination must be completed. Enrollment occurs after the client has completed and signed the Application and the Nurse Care Manager has completed the initial LOC certification.

3.420 Notification of Rights

The client must be notified of his/her rights by receiving copies of:

1) Client Rights in MSSP (Appendix 12); and
2) Your Rights Under California Welfare Programs (Appendix 13).

This form is available at:
http://www.cdss.ca.gov/cahwnet.gov/civilrights/PG394/.htm

The purpose is to provide information regarding client rights. The forms cover both the informal grievance process and the formal State Medi-Cal Hearings.

Clients must also be informed of the following:

- Circumstances which may cause loss of services.

- Termination procedures, including an explanation of the client's right to refuse or discontinue services.

- The local MSSP site's informal grievance process, including the name, address, and telephone number of the person(s) responsible for resolving complaints or initiating the grievance procedure.

- Any other information determined to be essential for the proper delivery of services.

3.500 Release of Client Information

3.510 Confidentiality

All client information is strictly confidential (Chapter 5 Client Records and Information, and Section 7.100 Confidentiality and Information Systems).

The Application informs the client that personal information will be shared among MSSP staff, governmental regulatory agencies, consultants and service vendors in order to facilitate service. Beyond those parameters, sharing and obtaining information requires the specific consent of the client. In all cases (including family members and caregivers) the client must sign a written consent to obtain or release such information (Authorization for Use and Disclosure of Protected Health Information form, Appendix 14).

3.520 Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI)

All pertinent data will be entered on the form (Appendix 14) before the client is asked to sign. Staff will not have clients sign blank forms. Each AUDPHI must specifically state the agency or individual who is to provide or receive the information, and the type of information to be exchanged. The AUDPHI may be used for a specific agency or individual or it may generically address an individual/entity when specifics are unknown e.g., "Attending Physician" or "Hospital".

The expiration date on the AUDPHI cannot exceed two years from the date of the client's signature.

If the client is unable to sign for themselves, the following individuals may sign for them:

1. Conservator. This is a person appointed by a court.

2. Agent. This is a person named in the client's power of attorney for health care.

3. Personal representative. This is an adult designated by the client, either in writing or orally, in the presence of an MSSP care manager.

Note: Clients must be offered copies of all signed AUDPHI's. If the client declines to receive copies, that information must be documented in the record.

3.530 Requests for Client Information

A request for information about a client requires the client's written consent.

3.600 Care Management

3.610 General Guidelines

Within MSSP, the care management process involves:

- Understanding the Waiver and other resources (community, Medicare, Medi-Cal State Plan, Title III, etc.).
- Conducting and documenting timely and comprehensive assessments and reassessments.
- Developing and updating a care plan and tracking outcomes.
- Coordinating services and/or purchases using waiver funds only for approved expenditures after other resources have been exhausted or are not available.
- Monitoring interventions and the impact on the client's functional abilities and goals.
- Documenting and record keeping.
- Terminating participation in the program.

The client's primary point of contact for the duration of their participation in the program is their care manager (CM). Care management is a cooperative collaboration between client and care manager. When a client is unwilling or unable to continue care management as evidenced by the client's lack of cooperation, the services of MSSP will be terminated following established termination guidelines (Section 3.1700 Termination).

The assessments, reassessments, care plans, progress notes and Service Plan and Utilization Summary (SPUS) are the tangible elements of the care management process. The goals and outcomes of care management must be clear. The client's choice and functional needs must be reflected and incorporated in the documentation.

Under the terms of the Waiver, certain care management activities (e.g., pre-screening and follow-up pending discharge) may be conducted while a client is in a NF or acute care hospital.

All other care management activities (assessments, reassessments and quarterly visits) must be conducted at the client's residence. Should it be necessary to conduct care management activities in an alternate location, the rationale for this decision must be documented in the progress notes. The only exception is under Deinstitutional Care Management (Section 3.1300).

3.620 Assessment/Initial Assessments

Assessment is the foundation of the care management process. Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive initial health and psychosocial assessments to determine specific problems, resources, needs, and preferences. Initial assessments are conducted by the NCM (Initial Health Assessment or IHA, Appendix 18) and the SWCM (Initial Psychosocial Assessment or IPSA, Appendix 19.) They do not have to be completed in any particular order; however the first one must be done within two weeks of the date of enrollment, and the other within two weeks of the first one. If this timeframe cannot be met, the reason for the delay must be documented in the client's progress notes. Shortage of staff is not an acceptable reason for delay.

An initial assessment requires a face-to-face interview with the client. Additional information may be obtained through contact with the family and other informal supports; contact with the client's physician and other health providers; as well as a review of the client's health/medical/psychosocial history. These contacts are made with the knowledge and consent of the client, or the client's significant support person who participates in the assessment and care planning process.

Initial assessments must be conducted in the client's place of residence. It is important to have a clear understanding of the home environment and the impact on the client's functioning since it is the goal of the MSSP to support a client's ability to live independently. Should it be necessary or advisable for the interview to be conducted in an alternate location, the rationale for this decision must be documented in the progress notes. Initial assessments will be reviewed for completeness of information and pertinent medical and social information relating to present conditions, function, and environment. All sections of the assessment information gathering tool (IHA or IPSA) must be completed. If information is unobtainable for some reason, the situation must be noted on the form. On occasion, completion of an item may be deferred. If completion of an item is deferred, the reason must be noted and a timeframe for obtaining the information included.

Explanatory comments must clearly indicate whether these are "subjective" or "objective/observed". The client's participation in the process should be clear by documenting their input regarding services or other information.

The initial health and psychosocial assessments must contain sufficient information to identify the following:

- Major problem areas.
- Client's strengths and resources.
- Client's functional level.
- Client's preferences or choice.
- Care manager's assessment of the client's situation.
- Congruity or lack of congruity between problems, functional level, choice, and needs.
- Implications for service delivery and care management.

The outcome of the assessment is a determination of:

  - The client's functional capacity to live independently.
  - The client's system, if any, that supports independent functioning.
  - What additional services or supports are needed to sustain the client with as much independence and self-determination as possible.

CDA required documents for assessments are available electronically and are referenced in Appendices 18 and 19. The assessment packet consists of the assessments (Initial Health Assessment and Initial Psychosocial Assessment) with supporting forms as detailed below:

The documents required by CDA consist of:

Initial Health Assessment (Appendix 18).

- Cover Sheet
- Initial Health Assessment
- Medication List
- Problem List
- IHA Summary

Initial Psychosocial Assessment (Appendix 19)

- Cover Sheet
- Initial Psychosocial Assessment
- Psychological Functioning
- CDA-Approved Cognitive Screening Tool*
- Functional Needs Assessment Grid (FNAG)

- Problem List
- IPSA Summary

*__Note__: CDA has approved the use of 4 screening tools: Folstein Mini Mental State Examination (MMSE); Montreal Cognitive Assessment (MoCA); Saint Louis University Mental Status Examination (SLUMS); and the Short Portable Mental Status Questionnaire (SPMSQ). See Appendix 19f.
Should a site elect to use a different cognitive assessment tool, a written request with a copy of the tool must be submitted to CDA for approval prior to adoption. Sites are responsible for obtaining the cognitive tool of choice.

Sites may use additional documents, including interview guides or check lists to collect the information for the assessment. This information should be incorporated into permanent case documents since informal notes should not be included in the client's file.

Each initial assessment must contain a summary which includes a **problem list** of issues/concerns that will be formulated into problem statements on the care plan.

3.630 Reassessment

The reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment. It is **not acceptable** to write in "no change" with no further explanation or to copy the prior re/assessment (cut and paste).

The reassessment document (Appendix 20) is available electronically as a form and consists of:

- Cover Sheet
- Functional Needs Assessment Grid (FNAG)
- CDA-Approved Cognitive Screening Tool (see Note in Section 3.620, Assessment/Initial Assessments)
- Medications List
- Problem List
- Reassessment Summary

Reassessments must be completed annually by either the NCM or SWCM. They require a face-to-face interview with the client, and must be conducted in the client's place of residence. As with the initial assessments, it is important to have a clear understanding of the home environment and its impact on the client's functioning. The reassessment should reference the interventions provided by MSSP during the prior year and whether the anticipated outcome was achieved.

Reassessments are reviewed for completeness of functional information and pertinent medical/social information relating to changes in conditions or situations. All sections must be completed. If information is unobtainable for some reason, the situation must be noted. On occasion, completion of an item may be deferred. If completion of an item is deferred, the reason must be noted and the timeframe for completion should be included. The reassessment must contain sufficient information to identify changes since the previous assessment in the following:

- Major problem areas.
- Client's strengths and resources.
- Client's functional level.
- Client's preferences or choice.
- Care Manager's assessment of the client's situation.
- Congruity or lack of congruity between problems, functional level, choice, and needs.
- Problem list based on the identified needs.
- Implications for service delivery and care management.

The outcome of the reassessment is a redetermination of:

1. The client's functional capacity to live independently.

2. The system that supports independent functioning, including the impact of services in the existing care plan.

3. Services and/or resources that are needed to sustain the client with as much independence and self-determination as possible.

The format of the reassessment document is the same regardless of the professional discipline of the care manager conducting the reassessment. All findings are to be recorded on a single document.

Some alternatives for staffing this responsibility include:

- Care managers performing the reassessment on their clients.
- Care managers within a team exchanging reassessments.
- NCM and SWCM jointly making the visit and completing the reassessment together.

Note: Sites must maintain a multi-disciplinary staffing model and ensure that each client is seen by both the NCM and the SWCM at least every 12 months (alternate discipline visit). For sites that combine the alternate discipline visit with the reassessment, it is acceptable to take advantage of the one month grace period for the reassessment.

Timeframe for reassessment:

- The month of initial enrollment is the foundation for future reassessments.

- A grace period of one month on either side of the anniversary month is acceptable. For example, if a client is enrolled in May, reassessments would always be due in May; however they could be done in April or June and still meet the required timeframe.

  Note: Conducting a reassessment in one of the months of the grace period does not change the anniversary month nor the LOC due date. **Each LOC creates the next LOC due date which must not exceed 365 days.**

- Sites have the option to re-set the reassessment calendar to a month different from the month of initial enrollment as the foundation for scheduling future reassessments. To re-set the reassessment calendar, the reassessment must be completed in **less than** 12 months and the progress notes must document both the change as being permanent and identify the new reassessment due date. **Note**: No client will go more than 12 months without a reassessment to convert to the new schedule.

  - *For example, if a client enrolls in February 2010, and the reassessment date is being moved to October, the first reassessment would be done in October 2010. The progress note documentation must include that the client's reassessment schedule has been changed to the month of October.*

  *Note: If LOC recertification is done at the time of reassessment, the **new LOC due date would be the anniversary date of the reassessment and must not exceed 365 days**.*

Care managers are encouraged to use collateral sources of information as reference points for the reassessment. Examples of these sources include: the current record; pertinent hospital discharge summaries and physical examination reports; home health agency records; other specialty reports such as occupational and physical therapy, nutrition consultation, etc. Sites may also use additional documents, including interview guides or check lists, to collect the information for the reassessment. Information collected in this manner must be incorporated into permanent case documents. Informal notes should not be included in the client's file.

3.640 Care Planning

Care planning is the process of developing an agreement between the client and care manager regarding identified problems, resources, outcomes to be achieved, and services arranged in support of goal achievement. These are detailed on a care plan.
The care plan provides a focus for the needs identified in the functional assessments, organizes the service delivery system to the client, and helps to assure that the service being delivered is appropriate to the client needs/problem. The care plan reflects services and resources necessary to support the client's ability to live in their community.

The MSSP interdisciplinary care management team must develop a comprehensive care plan for each client (Section 3.640.3 Care Plan Components; Section 3.640.4 Care Plan Activation: Signatures and Review Process, and Appendix 22a Care Plan Instructions).

The care plan must be:

- client centered,
- based on information found in the health and psychosocial assessment or reassessment,
- reflect all appropriate client needs,
- encompass both formal and informal services, and
- must be written within two weeks of the completed initial assessment or reassessment.

    - If the Initial Health Assessment is conducted on June 1 and the Initial Psychosocial Assessment on June 7, the care plan must be written by June 21.

    - If the assessments are completed concurrently on June 1, the care plan must be written by June 15.

The MSSP care plan includes:

- Problem statements derived from the problem list based on needs identified during the assessment process. Problem statements are individualized to capture the client's functional deficits which provide a clear picture of how the issues impact the client's ability to live independently.

- Measurable goals that demonstrate improvement based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client/family.

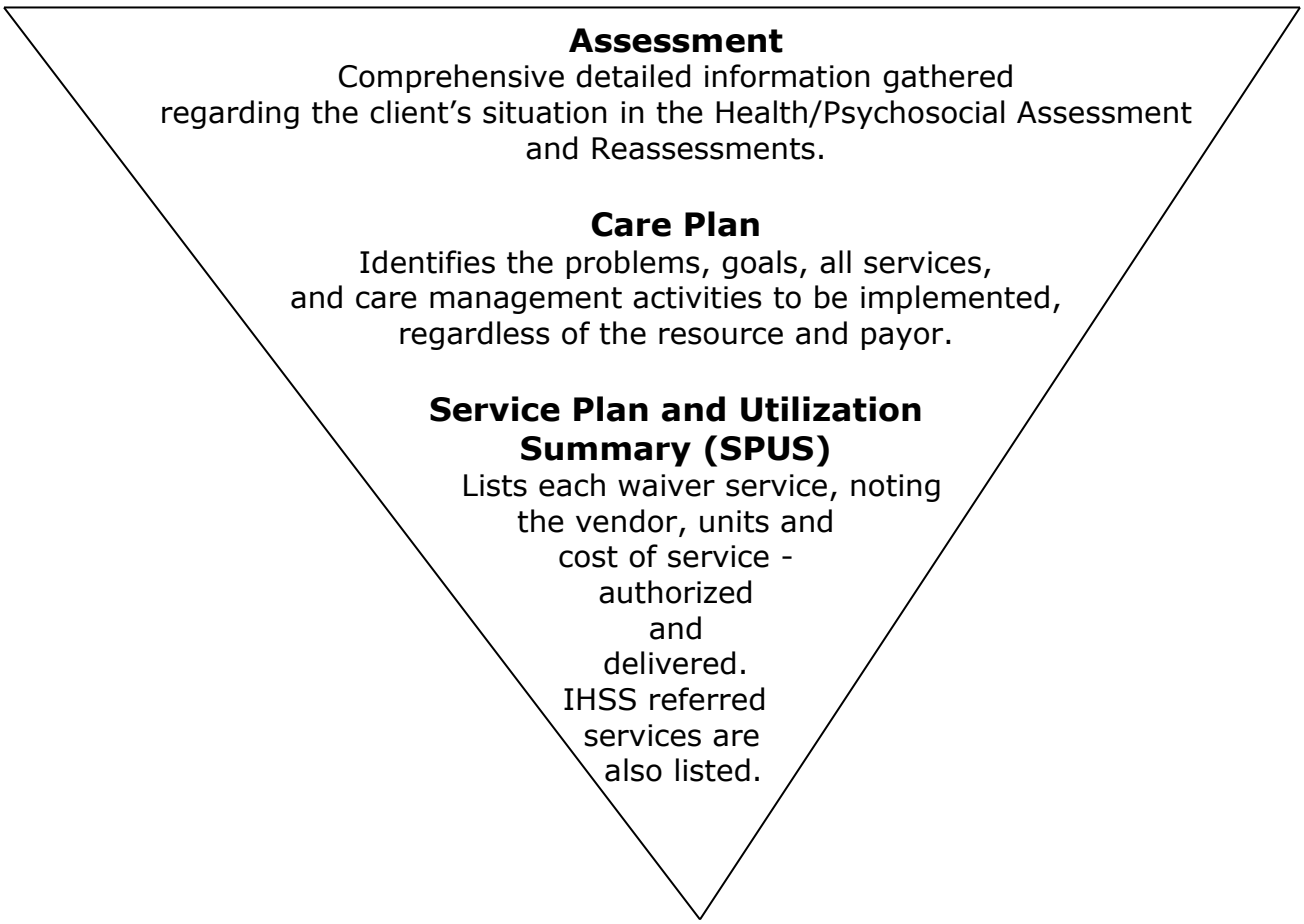
- Interventions to address the problems/needs.

- Service provider type (informal, referred, purchased) and name of provider/vendor (if known).

The care plan process also includes the Service Plan and Utilization Summary (Section 7.220 Service Planning and Utilization Summary SPUS; Appendix 25). The SPUS lists all waiver and IHSS referred services. It specifies the fund code, service provider, services authorized and delivered (unit, type, rate, and cost). This component is not generated at the onset of the care plan process but is tied by the historical tracking of all services provided to each specific client on a monthly basis.

3.640.1 General Guidelines:

The MSSP care plan (Appendix 22) reflects several elements that are interdependent. They must support each other and combined, validate the necessity and appropriateness of program services. The elements are illustrated in the following triangle.



Care planning is a continuous process that is client-centered. It begins with the assessment of the client's health and social needs followed by the development of a care plan, coordination of services, implementation, and ongoing monitoring and updating of the care plan.

The client and informal caregiver, or legal representative (as appropriate), will participate in the development of the care plan, and the client's preferences will be considered. The client must be given the freedom to choose:

1. Between waiver services and institutional care.

2. Waiver services and providers, as available in the local community.

Clients have the right to refuse specific service(s); however, when a service is refused, the risks and consequences associated with refusing the service must be addressed and documented in the client record (Section 3.700-3.740, Assessing and Documenting Client Risk).

The primary Care Manager (CM) is responsible for drafting the care plan document, which is followed by the "care plan conference" involving at a minimum three parties including the NCM, SWCM, the SCM or Site Director. The purpose of this team conference is to review the information assembled during the assessment process and draft a care plan to address the client's situation. The care plan conference must be conducted within 2 weeks of the last assessment/reassessment to meet care plan requirement timelines.

The care plan must be filed as part of the case record. Electronic recording may be utilized; however, a copy of the signed care plan must be in the case record. If care plans are updated electronically when a problem statement or intervention is added, the site must be able to produce a copy of the current document upon request. If a site uses NOAs to reflect changes, including additions, to the care plan, a copy of the NOAs must be in the case record.

Deferred interventions/services must have appropriate justification for the deferral documented in the client record. The methods of addressing any risk associated with the deferral must be documented. A timeframe for addressing the needs or providing the service(s) must be included in the documentation.

Note: If the care plan content (e.g., problem statement, goal, interventions) contains sensitive information (e.g., mental health issues; abuse or neglect by family member), that content may be modified to avoid placing the client's health or safety at risk. Details of the situation and the reason

for modifying the content of the care plan or the client's copy must be documented in the progress notes.

3.640.2 Emergency Care Plan

The initial care plan is developed prior to the delivery of any waiver services except in emergency situations.

There may be situations with new clients where upon initial visit to the home, MSSP staff identifies a situation or need of such a critical nature that it must be dealt with immediately rather than waiting for the regular Care Plan process. In these situations, the written approval of the SCM can initiate a service in response to this emergency. The situation must be fully documented in the progress notes. The problem/issue or intervention will then be included in the appropriate assessment and on the initial care plan.

3.640.3 Care Plan Components

Sites may modify the care plan form (Appendix 22); however, the basic integrity and all components of the form must be maintained with space allotted to record the required information. Although there are similar health and safety issues for all clients, the problem statements, goals, interventions and outcomes must be individualized to address the client's needs. The care plan document must include the following components:

A. Date(s)
   - Care Plan Conference date.
   - Duration of Care Plan – Typically twelve months beginning with enrollment month.
   - Date problem was originally identified/reconfirmed.

B. Problem #

   The "Problem #" section lists problem statements in a sequential manner. The care plan problem numbers remain the same as long as the problem is active. Resolved problem statement numbers can be reactivated due to recurrence of the issue. Numbers will be added sequentially as additional problems are identified, including new problems identified during annual reassessments.

   Care plan problem numbers can be renumbered at the time of the annual reassessment. Renumbering of problem statements should be documented in the Reassessment or Progress Notes. **NOTE**: Many problems remain active as long as the client remains in MSSP. Providing interventions usually does not result in resolution of client problems.

C. Problem Statement

1. Problem statements are derived from areas of concern identified in the re/assessments for which services and/or care management activities are provided. During the course of the year as new problems are identified, they must be added to the care plan.

   The medical diagnosis and the description of a client's functional deficits can be linked to describe a problem. Simply listing the medical diagnoses however, does not substantiate the need for services as it does not provide a clear picture of the client's functional deficits. Problem statements must be client centered, address the client's functional deficits that support the goals and link to the interventions. Problem statements are generally written in complete sentences.

2. If there are problem areas identified that will not be addressed in the care plan, an explanation must be documented in assessment and/or reassessment, or in the progress notes.

3. The problems identified on the care plan must:

   a. Justify the need for care management.

   b. Substantiate the need for service delivery, including informal, referred, and purchased services.

   c. Reflect the multi-disciplinary team collaboration on assessment findings. During the care planning conference, problems not identified prior to the conference should be added.

D. Service Provider Name and Type

The Service Provider and Type section lists the service provider(s) for all services and the type of provider(s) (Informal, Referred, Purchased, Care Management). More than one vendor/provider and type may be entered for an individual service. The name and type of provider(s) for each service will also be entered (Section 3.930, Authorization and Utilization of Services):

I = Informal: a service provided without cost through the client's network of family, friends, or other informal helpers (Section 3.1410 Informal Support)

R = Referred: a service (e.g., Meals on Wheels, transportation funded by Title IIIB,) provided without cost through referral to a formal organized program/agency (Section 3.1420 Referred Services).

P = Purchased: a service or item purchased with waiver service funds (Section 3.1420 Waiver Services).

C = Care Management: is the coordination of care and services provided to facilitate appropriate delivery of care and services (Section 3.1420 Waiver Services – Care Management 50, 4.3, and 4.6).

For purchased services/items using Waiver Service funds the site should enter the name of the service provider if known. A generic entry for a vendor (Big Box Store) or specific name (Target) can be listed on the Care Plan. Once a purchase is made, the name of the vendor and item(s) and/or service(s) purchased must be documented in the Progress Notes and on the SPUS. The provider information may also be added (handwritten or electronically) to the Care Plan when known. If the provider/vendor name is listed on the care plan in generic format or as a projected vendor, further clarification on the care plan is not required. The point of purchase must be on the SPUS and in the Progress Notes.

E. Goal

This section presents client goals for the identified needs or problems. The goal must be measurable and relate to the issues identified in the problem statement while linking to the interventions. The goal should reflect the client's input and consider the client's preferences.

Goals specify the skills to be acquired, behaviors to be changed, information to be provided, health and/or psychosocial conditions to be met. Measurable goals must describe desired outcomes and/or achievements. For example:

- During monthly contacts the client will report zero missed medical appointments.
- Client will report skin remains intact during each monthly contact.
- Client will maintain current weight of 150 lbs for the next six months as reported during monthly contacts.

F. Plan/Intervention
The Plan/Intervention section outlines possible actions, solutions, or plans to address the problem. Interventions that have the greatest probability of success are those that consider the client's preferences, perception of the problem or situation, and are compatible with the client's beliefs, values, and attitudes.

All interventions must be listed on the Care Plan. If an intervention is identified after the Care Plan was crafted, the intervention must be added (handwritten or electronically) to the Care Plan. Failure to record an intervention on the Care Plan could result in recovery of funds.

G. Date Resolved/Outcome/Comments
This section can be used to make notations regarding the name of the service provider, the date a service/item was provided, the outcome, and/or general comments.

3.640.4 Care Plan Activation: Signatures and Review Process

The care plan is written based on the documentation and findings in the assessment. Both the primary CM and SCM must sign the care plan within two weeks of the completion of the re/assessment. These signatures are required to activate the plan and to initiate purchases with waiver funds.

The client must also sign and date the care plan within 90 days of care plan activation. The client's signature indicates their acceptance of the plan but is not required prior to the commencement of any services.

Pending receipt of the client's signature on the care plan, documentation must demonstrate that the care plan has been reviewed with the client. Care managers must discuss all elements of the care plan with the client. This discussion and client's verbal acceptance must be documented in the progress notes if there is not a signed care plan. If the client's signature cannot be obtained within 90 days, the reason must be documented in the progress notes.

If the client is unable to sign for themselves, the following individuals may sign for them:

1. Conservator. This is a person appointed by a court.

2. Agent. This is a person named in the client's power of attorney for health care.

3. Personal representative. This is an adult designated by the client, either in writing or orally, in the presence of an MSSP care manager.

The care plan must be rewritten annually following the reassessment. New signatures are required after each reassessment and care planning conference (no later than 2 weeks after completion of the reassessment). The client signature is required within 90 days following the parameters described above.

3.640.5 Care Plan Implementation

MSSP interdisciplinary care management teams must maximize the use of the client's personal resources and other community resources before purchasing services/items using waiver funds. In authorizing services for a client, the care manager must use the following order of priorities:

1. All services available through the informal support of family, friends, etc., must be considered first, unless informal provision of services puts the client at risk; e.g., abuse, unskilled family member providing care, etc.

2. After the informal support services have been exhausted, referred services funded from other resources (public or private) for which the client is eligible and which are available in the community, must be used; e.g., Medicare, Medi-Cal, In-Home Supportive Services, Title III. When a service is available through Medi-Cal, these resources must be utilized to the maximum extent prior to the purchase of services with waiver funds. If a covered item or service is not available through Medi-Cal or other resources, documentation of the denial (including Treatment Authorization Request [TAR] and Medicare) must be included in client record or available upon request.

3. Identify the service/item to be purchased using waiver service funds. The vendor or vendor type should be listed with preference given to the most cost effective source. **Note**: Waiver services that are not included in the care plan are subject to recovery.

3.640.6 Care Plan Monitoring

Sites must review, verify, and document the following information each month:

- All care management activities,
- the status of each care plan problem statement, and
- the effectiveness of interventions implemented during the month.

The documentation style of the progress notes and how the problem statements are monitored is at the discretion of the site but must be consistent among the care management staff. The problem statements may be listed sequentially followed by a discussion of status, or imbedded in a narrative note. In either case, each problem statement must be addressed as it is the focal point of care plan monitoring (Section 3.820, "What Progress Notes Include"). Care plan monitoring must be documented in the progress notes each month including the month of reassessment.

Any deferral of interventions/services must have appropriate justification documented in the client record. Documentation must include a plan and time-frame when the issue will be addressed. The methods of addressing any risk associated with the deferral must be documented and followed up on a timely basis (Section 3.700 – 3.740 Assessing and Documenting Client Risk).

When the client makes their own arrangements for hiring or otherwise receiving any in-home services, including personal care, MSSP care management staff are not responsible for the monitoring or supervision of the service provider. However, the MSSP care manager is responsible for monitoring the health, safety and welfare of the client. The care manager will be responsible for discussing with the client or their representative, the client's health status and the care being provided. The care manager is required to report to the appropriate authority (e.g., Adult Protective Services or the client's physician), any areas of concern regarding a client, including any sign or symptom requiring professional evaluation or care.

The SPUS is considered a component of the care plan and must be signed and dated monthly by the primary CM to verify that the services were delivered as stated in the care plan. This signature indicates that any services purchased with MSSP funds are approved for payment. CDA requires that the final version of the SPUS that includes verified expenditures, be signed and available for review (Section 7.220 Service Planning and Utilization Summary [SPUS]). Note: As client costs increase, additional levels of approval may be required for the SPUS (Section 3.930, Authorization and Utilization of Services).

3.640.7 Care Plan Documentation Cycle (Retired)

3.640.8 Changes to the Care Plan

Care plan documents (e.g., the care plan and SPUS) must be updated/revised when warranted by changes in the client's condition, goals or service needs. Documentation of any changes occurring between assessment intervals must be recorded in the progress notes.

Clients will participate in any discussion or plans regarding any changes to their care plan. This participation will be documented in the progress notes and the changes made to the care plan. Changes to the care plan can be made electronically, handwritten on the existing care plan, or documented in NOA format and retained with the care plan.

NOTE: A notice of action (NOA) must be sent to clients for any adverse decision regarding waiver enrollment, or when a waiver service is reduced, suspended, terminated or denied (Section 3.1720 Notice of Action). Clients must be informed, in writing, of their right to request a State Medi-Cal Hearing (Appendix 5) regarding any adverse decision about enrollment, reduction, suspension, termination or denial of waiver services.

NOAs are not required for additions to the care plan. Should a site choose to issue NOAs when making additions to the care plan, a copy of the NOA must be maintained in the record as an active component of the care plan.

3.700 Assessing and Documenting Client Risk

Risk assessment facilitates the systematic exploration of situations that have a high possibility for adverse outcome.

3.710 Goal of Risk Assessment

MSSP clients have the right to refuse suggested interventions/services. If a client refuses an intervention/service, the site must have a process to verify that the risks associated with the refusal are addressed.

It is the expectation that MSSP care plans will reflect the participation and concurrence of the client. There may be situations in which the client chooses to pursue a course of action/behavior that the care manager may determine is detrimental to the client's health and/or safety; or the client may refuse interventions/services that, in the judgment of the care manager, are necessary to live safely. In most cases, it is sufficient to document the situation, including that the client was informed of the possible consequences of their decision.

There are situations where there is a high possibility of an adverse outcome e.g., smoking while using oxygen. Clients have the right to assume risk commensurate with their ability and willingness to understand and assume responsibility for the consequences of that risk. It is the responsibility of the care manager however, to assess if the risk is limited to the client or if the safety of others would be compromised as well.

3.720 Assessment of Ability to Assume Risk

In evaluating the client's ability to assume risk an assessment must include the following:

- Can the client make choices and communicate those choices?
- Can the client give reasons why the choice was made?
- Do the client's reasons for their choice make sense?
- Does the client understand the implications of the choice?
- Can the client consider the consequences of the choice?

3.720.1 Critical Incident Reporting

Care managers are mandated to report any known or suspected instances of abuse including physical, financial, neglect (including self-neglect) etc., to the appropriate local agency (e.g., APS, local law enforcement). Sites must report all incidences and known resolutions to CDA on the Quarterly Report.

3.730 Risk Management

A negotiated risk agreement will be developed when a situation arises where the client has chosen a course of action that may place them and/or others, including MSSP staff, at risk for a high possibility of an adverse outcome. The risk management plan will involve, and ultimately be signed, by the client and the care manager. The purpose is to stimulate creative thinking and generate a range of options.

The negotiated risk agreement (Appendix 24) will include at a minimum:

- A description of the situation.
- An explanation of the cause(s) of concern.
- The possible negative consequences to the client and/or others.
- A description of the client's preference.
- Possible alternatives/interventions to minimize the potential risk(s) associated with the client's preference/action.
- A description of the services or interventions, if any, that will be provided to accommodate the client's choice and minimize the risk.
- Frequency of reassessment of risk.
- The final agreement, if any, reached by all involved parties.

- The signatures of the client and care manager. If the client refuses to sign the negotiated risk agreement, the reason must be documented in the progress notes. **Note:** The client's refusal to cooperate may be grounds to begin the termination process under reason code 10. (Section 3.1710, Termination Codes and 6.400, Notice of Action for Termination). The termination process must be documented in the progress notes.

3.740 Monitoring of Risk

The status of the negotiated risk agreement must be monitored and documented monthly or at the agreed upon interval in the progress notes. The negotiated risk agreement must be reassessed at intervals mutually agreeable to the client and care manager. The interval will be determined by the nature of the individual situation (e.g., change in mental capacity or ability to understand risk/consequences).

3.800 Progress Notes

3.810 General Requirements

Progress notes must document all care management activity and must address each care plan problem statement monthly including the month of reassessment. All entries must be legible, dated, signed (Section 5.810, Staff Signatures and Signature Requirements) and conform to record keeping practices as described in Chapter 5. Lack of documentation of ongoing care management activities, including review of all active care plan problem statements, can lead to recovery of care management fees.

3.820 What Progress Notes Include

Progress notes are the ongoing chronology of the client's events and care management (Section 3.640.6, Care Plan Monitoring).

Progress Notes should address:

- Health and safety issues.
- The provision of interventions.
- Whether interventions are being delivered/implemented as anticipated.
- The client's response to the interventions.
- Whether interventions continue to be necessary.

Progress Notes must include the following:

- The date and type of MSSP staff contact with the client (whether the contact was a telephone call, home visit or other must be specified).

- A record of all events that affect the client (e.g., hospitalization, contact(s) with other agencies, falls, physician appointments, etc.).

- Discussion or plans between the care manager and the client regarding any changes to the care plan and the client's agreement to the change(s).

- The effectiveness of the interventions to address the needs described in the problem statements.

- Actions taken when interventions do not produce the desired outcome.

- Documentation addressing the status of each problem statement listed in the care plan, including justification for retirement of a problem statement.

- Any education or counseling provided to the client or caregiver to ensure that the needs of the client are met.

- Any significant information regarding the client's relationship with family, community or any other information which could impact the established goals for the client's independent living.

Note: Progress Notes for the **Quarterly Home Visit** should also provide an enhanced description of the client's status and include observations by the CM specific to the client's home environment and the interventions that have been implemented.

3.900 Managing Client Services

3.910 Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase supportive services from the list of approved Waiver Services. (Section 3.1430, Waiver Services). MSSP care managers are required to follow service authorization procedures prior to the use of Waiver Services.

3.920 The "Benchmark" And Calculation of Client Costs

All Medicaid waivers, including MSSP, are required to be cost-effective. The cost-effectiveness of MSSP is reported to CMS through the Annual Report on Home and Community-Based Services Waivers (CMS 372). Each year the formula in this report is used to demonstrate whether the average annual cost per MSSP/Medi-Cal recipient is less than the average annual cost per institutional care-based Medi-Cal recipient.

CDA designed the Benchmark to ensure that MSSP continues to meet this mandate for cost-effectiveness (Appendix 33).

Sites are not to enroll applicants whose cost for all Medi-Cal services is projected to exceed 100% of the Benchmark. After an individual has been enrolled and becomes a client, if their costs are projected to exceed the Benchmark, additional documentation is required (Section 3.150, Able to be Served Within MSSP's Cost Limitations).

3.930 Authorization and Utilization of Services

In authorizing services for a client, the care manager will use the following prescribed order of priorities (Section 3.640.5, Care Plan Implementation):

1. Informal services available through support of family, friends, etc., must be used whenever available.

2. Referred services may include:

    - Healthcare providers.
    - Title III Older Americans Act (Section 3.1420, Referred Services).
    - Title XVIII Medicare.
    - Title XIX Medi-Cal (TAR process).
    - Title XX Social Services.
    - Other publicly-funded services.

3. Purchased/Waiver services.
   After the client's informal support and community resources are exhausted, the care manager may request the use of MSSP funds to purchase waiver services (Section 3.1430 Waiver Services).

   Care managers must be aware of the cost associated with maintaining a client in MSSP. When considering the acquisition of client equipment, e.g., emergency response device or non-medical home equipment, it is important to analyze both the purchase and rental options to determine the most cost-effective approach.

   After the appropriate and necessary services have been identified, the care manager will develop a monthly cost estimate for each client's plan of care. At each site, the average monthly cost per client for all Title XIX services cannot exceed 95% of the average monthly cost of nursing home care. Client costs will be monitored and decisions to retain high cost clients in the program will be justified according to the following:

a. If during the screening process an MSSP applicant's ongoing costs are projected to exceed the cost of institutional care, the applicant is ineligible for the program. However, if there is a definite plan to bring these costs down to the Benchmark within three months, the applicant may be enrolled. Case documentation must identify the costs and the plan for managing them within the program limits.

b. The care manager may not authorize costs that exceed 95% of the Benchmark without the approval of the SCM (Section 5.810 Staff Signatures and Signature Requirements SPUS).

c. If the client's cost is expected to exceed 120% of the Benchmark, the Site Director's approval is required (Section 5.810 Staff Signatures and Signature Requirements SPUS).

d. If costs are expected to exceed 120% of the Benchmark for more than three consecutive months, the Site Director's approval is required, and case documentation should provide:

   - A summary of the availability to the client of family and friends including the number of hours they provide care, a description of the care provided and why they are unable to provide more care.
   - An analysis for reducing costs by shifting to other sources of care.
   - The clinical prognosis for the client.
   - Identification of the efforts the care manager has made to effect change (i.e., either working to change the situation of the client or to reduce costs), and the results of these efforts.
   - Identification of the expected outcomes for the client should termination from MSSP occurs.

e. In the event CDA reviews a record and finds insufficient documentation to support retaining the client on high cost status, the site will have 30 days in which to bring costs under Benchmark or terminate the client from the program as ineligible.

3.1000 Residential Care Facilities for the Elderly (RCFEs)

3.1010 Background Information

There are infrequent situations where it may be appropriate to have an MSSP client who is living in a Residential Care Facility for the Elderly (RCFE).

RCFE's are licensed by the California Department of Social Services, the Community Care Licensing Division (DSS/CCL).

The regulations that govern RCFE's are available online at: http://www.cdss.ca.gov/ord/entres/getinfo/pdf/rcfeman1.pdf (Title 22, Division 6, Chapter 8).

3.1020 Potential Conflicts

There are important issues that create potential conflicts for MSSP when serving RCFE residents. **MSSP services cannot duplicate or supplant what a facility is obligated to provide; and they do not relieve the licensee of the responsibility to meet all regulatory and statutory requirements.** RCFE's are to provide for all the needs of their residents. Services are divided into basic services and care and supervision.

Basic services include: "…safe and healthful living accommodations; personal assistance and care; observation and supervision; planned activities; food service; and arrangements for obtaining incidental medical and dental care (Title 22, Division 6, Chapter 8, Section 87101 b. [2])."

Care and supervision includes assistance with ADLs "and assumption of varying degrees of responsibility for the safety and well-being of residents." The tasks include assistance with dressing, grooming, bathing and other personal hygiene activities; taking medications; and central storage and distribution of medications. (Title 22, Division 6, Chapter 8, Section 87101 c [2].)

3.1030 When MSSP Can Serve RCFE Residents

There are two situations in which MSSP may work with an RCFE resident:

1. The individual is already an MSSP client, and is moving from a residential setting in the community into a RCFE.

   In this case, it is imperative that the MSSP care manager, in consultation with the client (their family, if appropriate) and the staff from the facility, develop a care plan that supports the client's relocation and period of adjustment to their new living situation. This transition plan, documented in the progress notes, will specify the services to be provided by the RCFE. If there is a continuing need for MSSP care management the care plan will identify the gap in RCFE service to be filled by MSSP, whether this is expected to be of short or long-term duration, and what resources exist or will be explored that can assume responsibility for any MSSP-provided service.

For example:

- One client may need to be followed for three months to ensure successful placement before being terminated by MSSP. The transition plan must be documented in the progress notes. The care plan must be revised to include the RCFE services.

- Another client may need on-going care management by MSSP and purchase of money management services. The care plan problem statement will be crafted addressing the need for this service and provide the interventions that will be the focus of MSSP activity. The care manager will follow the MSSP process for client contacts and documentation.

2. The individual is already living in an RCFE when the referral to MSSP is made.

   In this situation, the MSSP site must obtain copies of:

   - Documentation regarding the RCFE's assessment of the individual.
   - The admission agreement.
   - The needs and services plan completed by the facility.

The MSSP care plan must identify and include the services provided by the RCFE. **Note: It is imperative that diligence be exercised in assuring that MSSP does not duplicate or supplant services that are the responsibility of the RCFE.**

A review of the MSSP care plan must be conducted and the documentation of this review must be co-signed by the supervisor in the progress notes.

In the event CDA reviews a record and finds insufficient documentation to support MSSP services to an RCFE resident, the site will have 30 calendar days in which to provide acceptable documentation or terminate the client from MSSP.

3.1100 Hospice

3.1110 Hospice Services

Hospice services are available in most communities. Hospice is intended to address issues of end-of-life care including medical care, pain management, emotional and spiritual support tailored to the individual. Funding may come from Medi-Cal, Medicare or private sources.

3.1120 Coordinating MSSP and Hospice Services

Hospice services may be appropriate for some MSSP clients. In order to determine whether MSSP should continue to be involved with the client after they enroll in hospice, the MSSP care manager must determine what specific services hospice will provide, and what needs (if any) remain. **MSSP should not duplicate or supplant services being provided by hospice.** Each case should be evaluated individually because hospice programs differ and the availability of particular services may be contingent on their funding sources. The **MSSP care plan must be revised to include the hospice services** in cases where MSSP will continue to work with the client while they are in hospice**.** In other situations, where hospice can offer a complete array of services and there is no longer a need for MSSP care management, the MSSP case should be closed.

3.1200 Institutionalization

3.1205 (Section Retired)

3.1210 No Waiver Services Provided During Institutionalization

No Waiver Services are to be initiated for a client upon placement in a nursing facility or in a hospital with the following two exceptions:

1. The individual is being served under Deinstitutional Care Management (Section 3.1300 Deinstitutional Care Management, and Section 3.1430 Waiver Services; service code 4.6).

2. Personal Care (Service Code 3.2) may be provided for seven (7) calendar days (Section 3.1430 Waiver Services).

Immediately upon notification that a client has been placed in a nursing facility or hospital, the care manager will attempt to determine the probable length of placement. Wherever possible, pending or ongoing services will be immediately canceled or reduced.

If it appears that the client will be placed long term (more than 30 days), termination procedures should be promptly initiated. A 10 day notification is required (Section 6.400, Notice of Action for Terminations). If there is reasonable indication that the client will be institutionalized on a short term basis (30 days or less), termination procedures are not necessary.

During institutionalization, contacts by the care manager to obtain client status are appropriate. After 30 calendar days of institutionalization, unless definite plans for discharge are being made by the institution and are documented in the client's record, the client must be terminated from MSSP.

3.1300 Deinstitutional Care Management[1]

3.1310 Background

In May 2002, an amendment to the MSSP waiver was approved that allows MSSP care managers to begin working with individuals while they are still residents of an institution (acute hospital or nursing facility). Under this amendment, Deinstitutional Care Management (DCM) services can be provided during the last six months of an institutional stay to facilitate the resident's successful discharge to community living.
The services available under DCM include all of the services currently offered under the waiver: care management to assist in the planning and preparation for discharge, and the actual purchase of some goods and services (e.g., installation of a ramp, provision of money management).

3.1320 Waiver Status of Recipients of DCM Services

Although waiver services may be provided to an institutionalized resident, the individual cannot actually be enrolled into the MSSP waiver. Sites cannot bill for services provided (Section 9.110, Billing Process) while the client is institutionalized; however, they can report the client in their active caseload until the date of discharge from the institution. Individuals receiving services under DCM have the same rights as waiver clients, including access to State Fair Hearings to resolve disputes.

3.1330 Outreach and Case Finding

Outreach and case finding for potential DCM recipients will incorporate many activities similar to traditional program outreach. Beginning with a well-defined outreach plan, the focus for DCM services will be targeted to those entities most likely to have access to individuals who either are, or will likely be, residents of nursing facilities. In addition to the nursing facilities, potential referral sources include discharge planners in acute care hospitals, rehabilitation centers, transitional care units, first responders, and local facility Ombudsmen.

Another source of referrals is the MSSP site itself. MSSP clients who are terminated from the program due to institutionalization may be candidates to return to the community following a stay in a nursing facility. Sites may want to establish a system for follow up with these terminated clients so that DCM services can be initiated when appropriate.

[1] The term used by CMS is "Transitional Case Management "(TCM). However, in practice in California, this terminology is consistently confused with Targeted Case Management (TCM). To avoid this confusion, MSSP has adapted the federal terminology, changing the phrase to Deinstitutional Care Management.

3.1340 Screening for DCM Services
New referrals of individuals who may be appropriate for DCM services will be screened using the site's established screening tools and processes. The screening tool used will be retained either in the case record (if the individual goes on to receive services) or in a separate file maintained for all referrals that are screened out (Section 3.230, Referrals not Accepted for MSSP Participation).

3.1350 Request for DCM Services

3.1351 Request for DCM Services Form
Persons screened for DCM services will complete a Request for Deinstitutional Services (Appendix 11a) and be given a copy of the form.

As noted in Section 3.1310, DCM services are limited to the final six months of an institutional stay. If the discharge decision has not been acted on during that six-month period, the DCM case must be closed. The individual can be referred for DCM services at a later date should their situation change.

3.1352 Denial of DCM Services
Persons screened for assessment of appropriateness of DCM services, but subsequently denied participation, are provided written explanation for the reason for denial in a Notice of Action (Appendix 2) and have the right to a State Medi-Cal hearing in accordance with Welfare and Institutions Code, Sections 10959-67 (Appendix 1). Persons who choose not to participate, or do not meet program criteria for age, Medi-Cal eligibility, or residence, will be informed they may contact the program at a later date should their situation change. A Notice of Action is **not** required.

3.1360 Deinstitutional Services Assessment
Following the completion of the Request for Services form, the Deinstitutional Services Assessment (Appendix 11b, c) will be completed. The process of the DCM Assessment is the same as the standard MSSP assessment (Section 3.620, Assessment/Initial Assessments): gather pertinent information relative to the individual's needs regarding their ability to transition to and live in a non-institutional setting.

For individuals who were terminated from MSSP within three months of requesting DCM services, an abbreviated assessment process may be conducted in lieu of completing the entire DCM Assessment form. At a minimum, this abbreviated assessment will consist of the functional needs assessment grid from the DCM Assessment, a brief summary, and a problem list identifying areas that need to be addressed to facilitate a successful discharge back into a community living situation.

Should the care manager determine that additional information or sections of the DCM Assessment document are necessary to accurately assess the individual's situation and potential for discharge, they should expand the abbreviated assessment process to accommodate those needs.

3.1370 Plan for Deinstitutional Services

Beginning with the Assessment and utilizing any other pertinent information, the care manager will work with the individual to develop a Deinstitutional Care Plan (DCP) (Appendix 11e). Collaboration between the NCM and SWCM will be reflected in the case documents (e.g., participation in the care planning conference), and the DCP will reflect input from both health and social work disciplines. The DCP will be signed by the CM and SCM to authorize necessary expenditures. The individual will also sign to indicate their agreement with the proposed DCP.

The DCP, developed within two weeks of the Assessment, will list both the DCM services that will be provided prior to discharge, and an estimate of the MSSP waiver services that will be required upon enrollment into the waiver. As noted in Section 3.1310, the services available under DCM include all services that are offered under the waiver (Section 3.1430 Waiver Services):

- care management to assist in the planning and preparation for the client's discharge home, and
- actual purchase of goods and services (e.g., installation of a ramp, provision of money management).

Authorization of DCM services will follow the same order of priorities for all MSSP services (Sections 3.640.5 Care Plan Implementation and 3.930 Authorization and Utilization of Services): informal support from family and friends will be utilized first, followed by services available from other public and private resources. Only when these first two resources have been exhausted can MSSP funds be used to purchase services from the list of those defined under the waiver.

On-going communication with the nursing facility/institution staff is critical to ensure coordination of timeframes, activities and services necessary to effect a successful discharge to the community.

Progress notes must document all care management activity (including interdisciplinary collaboration) while the individual is receiving DCM services. Entries will be made at least monthly, and will meet all requirements for MSSP progress notes as described in Section 3.820.

3.1380 Conclusion of DCM Services

There are two outcomes for recipients of DCM services:

1. Qualified and enrolled in MSSP.
   These individuals successfully transition from the facility to the community and enroll in MSSP.

   The standard enrollment process including all required forms must be completed. The client is counted in the site's caseload.

   Note: Billing for DCM services occurs upon discharge (Section 9.110 Billing Process [a]). Sites can only bill once per month for Care Management and Care Management Support services. During the month of enrollment into MSSP, these services should be billed under the waiver rather than included in the DCM billing.

2. Not enrolled in MSSP.
   These individuals do not transition to the MSSP waiver for one of a variety of reasons (e.g., changed their mind; death; discharged but lack a qualifying Medi-Cal aid code).

   Note: Billing for any DCM services rendered occurs as soon as the decision is made not to enroll. (Section 9110 Billing Process [b]).

3.1381 Data Reporting

Upon completion of DCM services, the supervisor will complete the DCM Data Tracking form (Appendix 11h). A copy of this form will be filed in the individual's case record at the site, and one copy will be transmitted to CDA with the site's next Quarterly Report.

3.1390 Out of Area Referrals

Each site's contract with CDA defines the area it serves. It is possible that a site could receive a referral for DCM services where either:

1. The nursing facility/institution where the individual currently resides is outside the site's service area, but the individual intends to be discharged to a residence within the site's boundaries; or

2. The facility is in the site's service area, but the individual intends to live in a residence outside those boundaries.

In addressing these issues, the primary considerations should be to minimize disruption and maximize continuity and quality of services for the individual.

If the nursing facility/institution and the individual's intended residence could reasonably be served by one site, that is the site that should receive the referral and begin work with the individual. Considerations to keep in mind include:

- Relationship with the nursing facility/institution. One site may have developed a working relationship with the institution that would allow them to interact more effectively with discharge planners and other health care personnel.

- Knowledge of local services and resources.

- If it is necessary for one site to initiate DCM services and it is known that the individual will have to receive on-going services from another MSSP site, coordination between the initiating and receiving site must be maintained from the beginning. (Section 3.1800, Transfer of Clients Between Sites).

3.1400 Description of Services

There are three major categories of services available to MSSP clients. They are: Informal Support, Referred Services, and Waiver Services.

3.1410 Informal Support

These services are provided to the client at no cost to MSSP. Examples of services include, but are not limited to:

- The client's spouse.
- Family (children, siblings, parents).
- Relatives (other than immediate family).
- Friend/neighbor.
- Religious/spiritual support.
- Volunteers.

3.1420 Referred Services

These services are available in the community and funded by sources other than the MSSP waiver. The main sources of these services are:

- Medicare (Title XVIII):
  Title XVIII of the Social Security Act, is the national health insurance program for the elderly and disabled. The Medicare program is divided into the following:

  - The hospital insurance portion (Part A) covers in-patient acute care costs and home health agency costs.

- The supplemental medical insurance program (Part B) covers out-patient costs.

- The Medicare Prescription Drug Program (Part D) provides prescription drugs to Medi-Cal recipients.

➢ Medicaid Program (Title XIX):
Title XIX of the Social Security Act enables states to provide medical assistance to families with dependent children, aged, blind, permanently and totally disabled individuals who cannot afford such services. The program is called Medicaid nationally and "Medi-Cal" in California. It is administered at the state level by the Department of Health Care Services (DHCS), the Single State Agency for Medicaid.

The Centers for Medicare & Medicaid Services (CMS) has federal responsibility for monitoring program compliance and financial participation. Medi-Cal services available under the State Medicaid plan include: physician services, hospital services, medications, and other medical benefits (including Durable Medical Equipment).

➢ Most MSSP clients receive either PCSP or In-Home Supportive Services under the State Plan. Advocating for clients to receive the appropriate level of service from IHSS and intervening to assure that problems are addressed are regular activities for MSSP care managers. Recognizing the importance of coordinating services between MSSP and PCSP/IHSS, CDA and DSS have entered into a Memorandum of Understanding (Appendix 44). This agreement provides that county welfare offices (administrators of PCSP/IHSS) will not count MSSP services as an "alternate resource" in assessments for PCSP/IHSS. In turn, through its use of Waiver Services, **MSSP may supplement but not supplant PCSP/IHSS.**

NOTE: Medi-Cal and Medicare services may not be purchased with MSSP funds. Sites are not required to report Medi-Cal or Medicare service costs on the SPUS (with the exception of IHSS). However, Medi-Cal and Medicare services must be documented on the care plan.

➢ Title III, Older Americans Act: Title III services are provided by local agencies under contract with the Area Agency on Aging (AAA). The availability of these client services differ across the State. Refer to Appendix 36, Title III Services, for the range of services funded by Title III through AAA. Services received by a client through Title III should be referenced on the Care Plan although they are not reported in the MSSP automated services system (SPUS).

- Additional Community Resources: Services provided by any other source. These services, while available to clients and included in care plans, are not reported in the MSSP automated services system (SPUS).

3.1430 Waiver Services

To provide for the additional services needed by the program's frail elderly clientele, MSSP requested and received waivers under Title XIX (Medi-Cal). The waivers added several services to those that may be provided using existing Title XIX funds.

MSSP Waiver Services cannot be purchased until the preceding categories of services have been exhausted. **Note:** Family members will not be reimbursed for the provision of any service provided under the Waiver.

The following criteria must be met and documented in the case record:

- The client's assessment identifies the need for the services/items including how it is a necessary support if the client is to remain in the community, and the care plan specifies the service(s)/item(s).

- The client is receiving Deinstitutional Care Management services, and the services/items are required to facilitate discharge from the institution to a community residence, and the care plan specifies the services/items.

- The services/items are unobtainable through other resources.

- The services/items are necessary to preserve the client's health, improve functional ability and assure maximum independence, thereby preventing elevation to a higher level of care and avoiding more costly institutionalization.

Licensing and certification requirements for specific Waiver Services are summarized in Appendix 26.

The services approved for purchase under the MSSP waiver are:

Adult Day Support Center (1.0): ADSC's are community-based programs that provide non-medical care to meet the needs of functionally-impaired adults. Services are provided according to an individual plan of care in a structured comprehensive program that will provide a variety of social, psychosocial, and related support services in a protective setting for less than a 24-hour basis.

The State Department of Social Services (DSS) licenses these centers as community care facilities. Alzheimer's Day Care Resource Centers (not licensed by DSS) are also eligible providers.

Eligible clients are those who:

- Need but do not have a caregiver available during the day.
- Are isolated and need social stimulation.
- Need a protective setting for social interaction.
- Need psychological support to prevent institutionalization.

Care in adult day support centers will be provided when specific therapeutic goals are stipulated in the client's plan of care. Adult day support center care is not meant to be merely diversional or recreational in nature.

Adult Day Care (1.1): Adult day care centers are community-based programs that provide non-medical care to persons 18 years of age or older in need of personal care services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual for less than a 24-hour basis. Services are provided to clients who have been identified as benefiting from being in a social setting with less intense supervision and fewer professional services than offered in an adult day support center. Adult Day Care services will be provided when the client's plan of care indicates that the service is necessary to reach a therapeutic goal. The State Department of Social Services (DSS) licenses these centers as community care facilities. Alzheimer's Day Care Resource Centers (not licensed by DSS) are also eligible providers.

Housing Assistance (2.2, 2.3, 2.4, 2.5 and 2.6): these services are necessary to ensure the health, welfare and safety of the client in their physical residence or home setting.

As specified in the client's plan of care, services may include provision of physical adaptations and assistive devices, and emergency assistance in situations which demand relocation and assistance to obtain or restore utility service. Definitions for specific Housing Assistance services follow.

Minor Home Repairs and Adaptive Equipment (2.2): minor home repairs do not involve major structural changes or repairs to the dwelling. Adaptive equipment is defined as those services necessary for access (e.g., ramps, handrails; items above what are covered by the State Plan and, installation), safety (e.g., electrical wiring, smoke alarms), or security (e.g., locks).

Eligible clients are those whose health and/or safety or independence are jeopardized because of deficiencies in their place of residence. This service is limited to clients who own and reside in their own home, or those in rental housing where the owner refuses to make needed repairs or otherwise alter the residence to adapt to special client needs.

Written permission from the landlord (including provision for removal of modifications, if necessary) is required before undertaking repairs or maintenance on leased premises. All services shall be provided in accordance with applicable State or local building codes.

Non-medical Home Equipment (2.3): includes those assistive devices, appliances and supplies that are necessary to assure the client's health, safety and independence. This service includes the purchase or repair of nonmedical home equipment and appliances such as refrigerators, stoves, microwave ovens, blenders, kitchenware, heaters, air conditioners, fans, washing machines, dryers, vacuum cleaners, furniture (i.e., mattresses and bedding, lamps, tables, couches, chairs [including recliners and lift chairs]), and emergency supply kits.

Emergency Move (2.4): involves facilitating a smooth transition from one living situation to another. Eligible clients are those who, due to loss of residence or the need for a change in residence, require assistance with relocation. Services may be provided by moving companies or other individuals who can guarantee the safe transfer of the client's posses-sions. Activities may include materials and labor.

Emergency Utility Service (2.5): allows for payment of utilities only when the client has no other resources to meet this need. The client must be at risk to receive or has already received a shut-off notice and the potential shut off of utility services would place the health and safety of the client in jeopardy.

Temporary Lodging (2.6): allows for payment of hotel or motel lodging for those clients, usually from rural areas, who must travel long distances and stay overnight for medical treatments not available in their home area. Lodging rates shall not exceed State per diem limits; these limits vary depending on geographic area.

Supplemental Chore (3.1): is for purposes of household support and applies to the performance of household tasks rather than to the care of the client. Chore activities are limited to: household cleaning, laundry (including the services of a commercial laundry or dry cleaner), shopping, food preparation, and household maintenance, as long as the client does not live in a Residential Care Facility for the Elderly (RCFE).

Instruction in performing household tasks and meal preparation may also be provided to the client under this category.

This service is for purposes of household support for those services above and beyond those available through the residual In-Home Supportive Services (IHSS) Program or to clients that are not eligible for IHSS. Examples include:

1. The client is not eligible for IHSS.

2. The MSSP client has not yet been assessed for IHSS, and needs services in the interim until IHSS can be arranged.

3. The regular IHSS provider is not available.

4. IHSS services are in place; however, MSSP has assessed a greater need. In these cases MSSP will advocate with IHSS for increased time for those services before authorizing expenditure of waiver funds.

NOTE: Services purchased using 3.1 can supplement but not supplant IHSS.

Supplemental Personal Care (3.2): is provided to those clients whose needs exceed the maximum amount available under IHSS or who are in circumstances where the individual lacks a provider. Services under this category provide assistance to the client to maintain bodily hygiene, personal safety, and activities of daily living which are essential to the health and welfare of the recipient.

These tasks are limited to non-medical personal services such as:

- Feeding.
- Bathing.
- Oral hygiene.
- Grooming.
- Dressing.
- Care of and assistance with prosthetic devices.
- Rubbing skin to promote circulation.
- Turning in bed and other types of repositioning.
- Assisting the individual with walking.
- Moving the individual from place to place (e.g., transferring).

Client instruction in self-care may also be provided and may include assistance with preparation of meals, but does not include the cost of the meals themselves.

When specified in the plan of care, this service may also include such housekeeping chores as:

- Bed making.
- Dusting.
- Vacuuming.

Any household chores which are performed by the worker are ancillary to the provision of the client-centered care. Thus, if food is spilled, it may be cleaned up, and when bed linen is soiled it may be changed, washed, and put away. However, at no time would household chores become the central activity furnished by a personal care worker.

Purchase of personal care supplies may be covered where there are no other resources. These items include supplies not covered under the State Plan.

When a personal care service is to be performed by a caregiver, the duties will be limited to those allowed by the worker's employer, or permissible according to the Board of Registered Nursing policy on unlicensed assistive personnel, and as permitted by the worker's certification (if applicable).

Personal care service providers may be paid while the client is institutionalized. This payment is made to retain the services of the care provider and is limited to seven (7) calendar days per institutionalization.

NOTE: Services purchased using 3.2 can supplement but not supplant IHSS.

Supplemental Health Care (3.3): addresses the care of health problems by appropriately licensed or certified persons when such care is not otherwise available under the State Plan. These services will be provided based on the following criteria:

- The client assessment identifies need for this support and the care plan reflects the required services and/or items.

- MSSP must utilize all of the health care services available under Medicare (when clients have Medicare), other health coverage, and the State Medicaid Plan prior to purchasing these services as waiver

services. MSSP clients are extremely frail and, on occasion, need health-related services that are not provided under Medicare and/or Medi-Cal, e.g., no Medi-Cal provider in that local area.

- This service supplements benefits provided by the existing Medicare and Medi-Cal programs including managed care, using providers who meet standards under Provider Qualifications: Licensure and Certification, Appendix 26.

- The service is provided by authorized individuals when such care is prescribed or approved by a physician.

- Services may include the following professionals/services:

  1. Pharmacists: pharmacy consultations.

  2. Registered nurses or licensed vocational nurses: skilled nursing services.

  3. Nutritionists/Registered Dietitians: nutritional assessment or counseling.

  4. Occupational, physical, or speech therapists; consultation, including client assessment, training, and planning.

  5. Other health professionals specific to the identified need of the client.

Supplemental Protective Supervision (3.7): ensures provision of supervision in the absence of the usual care provider to persons in their own homes who are very frail or may suffer a medical emergency, to prevent immediate placement in an acute care hospital, nursing facility, or other 24-hour care facility, e.g., Residential Care Facility for the Elderly (RCFE). Such supervision does not require medical skills and can be performed by an individual trained to summon aid in the event of an emergency. This service may also include checking on a client through a visit to the client's home to assess the situation during an emergency (e.g., natural disaster).

Supplemental Professional Care Assistance (SPCA)(3.9): this service is covered by Medicare and requires the client to have a skilled need and physician's order on file. SPCA is a comprehensive skilled service delivered by a certified home health aide (CHHA). The CHHA works under the supervision of a registered nurse employed by a certified home health agency.

Care Management (50, 4.3 and 4.6): assists clients in gaining access to needed waiver and other State Plan services, as well as needed medical, social, and other services, regardless of the funding source.

Care managers are responsible for ongoing monitoring of the provision of services included in the client's plan of care. Additionally, care managers initiate and oversee the process of assessment and reassessment, recertification of client level of care, and monthly review of care plans.

Site-Provided Care Management (50): MSSP care management includes:

- Assessing.
- Care planning, authorization of services.
- Locating, coordinating and monitoring a package of long-term care services for community-based clients.

MSSP utilizes a care management team comprised of a nurse and social worker. The team is responsible for care management services including the assessment, care plan development, service authorization/delivery, monitoring, and follow up components of the program. Although the primary care manager will be either a nurse or social work care manager, both professionals will be fully utilized in carrying out the various care management functions.

Purchased Care Management (PCM)(4.3): typically care management services are provided solely by site care management staff. However, clients have the right to request care management by qualified outside vendors (2.010 Minimum Qualifications). In certain instances, the site may elect to utilize Purchased Care Management.

When the site's Care Management staff is unavailable due to a medical leave of absence (3 months or less), Purchased Care Management services can be used for temporary coverage. The individual must meet minimum qualifications of the position (2.010 Minimum Qualifications). Note: PCM cannot be used to fund permanent staffing needs of the site.

Additional case-specific resources may be purchased under PCM: social and legal and/or paralegal specialists in the community in order to augment the resources and skills of site-based case managers. Examples include the purchase of skilled diagnostic and consultant services by social and legal or paralegal professionals. Fees necessary to procure birth certificates or other legal documents required for establishment of public benefits or assistance are also covered.

Deinstitutional Care Management (DCM) (4.6): is used ONLY with individuals who are institutionalized (Section 3.1300 Deinstitutional Care Management). It allows care management and waiver services to begin up to 180 days prior to an individual's discharge from an institution. It may be used in two situations, as follows:

1. Where MSSP has gone into a facility (nursing facility or acute hospital) to begin working with a resident to facilitate their discharge into the community.

2. Where a prior MSSP client is institutionalized and MSSP services are necessary for the person to be discharged back into the community.

In either situation, all services (monthly Care Management Support and Care Management, plus any Waiver Services) provided during this period are combined into one unit of DCM and billed upon discharge. For those individuals who do not successfully transition to the waiver, all services provided are combined into one unit of DCM and billed at the end of the month the decision is made to cease MSSP activity (Section 9.110 Billing Process).

Respite (5.1, 5.2): Medi-Cal does not provide for respite care. By definition, the purpose of respite care is to relieve the client's informal caregiver and thereby prevent breakdown in the informal support system. Respite service purchased with Waiver Service funds will include the supervision and care of a client while the family or other individuals who normally provide unpaid informal care take short-term relief or respite which allows them to continue as care-givers. Respite may also be needed in order to cover emergencies and extended absences of the regular paid caregiver.

In situations where a caregiver provides both paid and unpaid care, it is important to distinguish between providing respite (for unpaid time) and substitution or augmenting paid hours. An example is when a family member is being paid by IHSS as the client's Individual Provider (IP) for a certain number of hours and tasks, but this caregiver also puts in time that is not reimbursed by IHSS. If the problem is that the IHSS hours are insufficient, the first recourse is to intercede with IHSS and advocate for a reassessment to incorporate the additional necessary care. If unmet needs remain and there is justification to expend waiver funds, appropriate services to consider include:

3.1 (Supplemental Chore)
3.2 (Supplemental Personal Care)
3.7 (Supplemental Protective Supervision)

It is not appropriate to purchase any waiver service for hours for which an IP receives pay. If an IP needs a break or vacation, a substitute or temporary IP should be found to work the hours paid by IHSS (the regular IP would not be paid for this time since they would not be working). Coverage of the unpaid hours could be considered for respite under the waiver.

As indicated by the client's circumstances, services will be provided In-Home (5.1) or Out-of-Home (5.2) through appropriate available resources such as board and care facilities, skilled nursing facilities, etc. Waiver Service funds will not be used for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. Individuals providing services in the client's residence shall be trained and experienced in personal care, homemaker services, or home health services, depending on the requirements in the client's care plan.

Transportation (6.3 [hour] and 6.4 [one-way trip]): these services provide access to the community (e.g., non-emergency medical transportation to health and social service providers) and special events for clients who do not have means for transportation or whose mobility is limited, or who have functional disabilities requiring specialized vehicles and/or an escort. These services are different from the transportation service authorized by the State Medicaid Plan which is limited to medical services or clients who have documentation from their physician that they are medically unable to use public or ordinary transportation.

Informal services such as family, neighbors, friends, or community agencies which can provide this service without charge will be utilized whenever possible.

Transportation services are usually provided under public paratransit or public social service programs (e.g., Title III of the Older Americans Act) and shall be obtained through these sources without the use of MSSP resources, except in situations where such services are unavailable or inadequate.

Service providers may be:

- paratransit subsystems of public mass transit.
- specialized transport for the elderly and handicapped.
- private taxicabs when they are subsidized by public programs or local government to serve the elderly and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for the elderly and handicapped).

- private taxicabs when no form of public mass transit or paratransit is available or accessible.
- contracted vendors that offer transportation as one of the array of services.

Escort services will be provided when necessary to assure the safe transport of the client. Escort services may be authorized for those clients who cannot manage to travel alone, and require assistance beyond what is normally offered by the transportation provider. This service will be provided by trained paraprofessionals or professionals, depending on the client's condition and care plan requirements.

Nutritional Services (7.1, 7.2, and 7.3): these services may be provided daily, but are not to constitute a full nutritional regimen (three meals a day) [42 CFR 440.180 (b)].

Congregate Meals (7.1): meals served in congregate meal settings for clients who are able to leave their homes or require the social stimulation of a group environment in order to maintain a balanced diet. Congregate meals can be a preventive measure for the frail older person who has few (if any) informal supports, as well as a rehabilitative activity for people who have been physically ill or have suffered emotional stress due to losses associated with aging. This service should be available to MSSP clients through Title III of the Older Americans Act. MSSP funds shall only be used to supplement congregate meals when funding is not available or is inadequate through Title III or other public or private sources.

Home Delivered Meals (7.2): prepared meals for clients who are homebound, unable to prepare their own meals and have no caregiver at home to prepare meals for them. The primary provider of this service is Title III of the Older Americans Act. Waiver Service funds shall only be used to supplement home-delivered meals when they are unavailable or inadequate through Title III or other public or private sources.

Food (7.3): provision of food staples is limited to purchase of food to facilitate and support a client's return home following institutionalization, and to food purchases which are medically required.

Effective October 1, 2011, the Medi-Cal ONS benefit is limited to products administered through a feeding tube and in some cases, for individuals with a diagnosis of malabsorption and inborn errors of metabolism. If ONS are to be included in the care plan, the care management staff should confirm that the client is not eligible for ONS through Medi-Cal.

If ONS are to be purchased with waiver services funds, the following must be recorded in the client record:

- The nurse care manager has assessed the client's nutritional needs and concluded that ONS is advised.
- The use of home-prepared drinks/supplements (e.g., instant breakfast, pureed food) has been explored and found not to meet the client's needs.
- All other options for payment of ONS have been exhausted.

If all three criteria have been satisfied, ONS may be purchased initially for a period of three months. When it is determined that it is desirable to continue beyond that time, the client's physician must be notified and a physician order must be obtained. The physician's order must be renewed on an annual basis or more frequently as needed.

Additional supporting documentation may include:

1. A nutritional screening recommending this alternative, preferably a consultation or assessment obtained from a nutritionist or dietitian.

2. A nutritional screen (see Appendix 21 for an example of a nutritional screen) conducted by the primary care manager in consultation with the nurse care manager. The Progress Notes must reflect the collaboration between the SWCM and NCM.

When the client or family is purchasing ONS, the care manager should advise them to notify the client's physician.

Protective Services (8.3, 8.4 and 8.5): these services include protection for clients who are isolated and homebound due to health conditions; who suffer from depression and other psychological problems; individuals who have been harmed, or threatened with harm (physical or mental) by other persons or by their own actions; or those whose cognitive functioning is impaired to the extent they require assistance and support in making and carrying out decisions regarding personal finances.

Social Support (8.3): this service includes periodic telephone contact, visiting or other social and reassurance services to verify that the individual is not in medical, psychological, or social crisis, or to offset isolation. These services are often provided by volunteers or through Title III of the Older Americans Act; however, these services may not be available in a particular community. The waiver will be used to purchase friendly visiting only if the service is unavailable in the community or is inadequate as provided under other public or private programs.

Expenses for activities and supplies required for client participation in rehabilitation programs, therapeutic classes and exercise activities can also be provided. Such services shall be provided based on need as designated in the client's care plan.

Therapeutic Counseling (8.4): this service includes individual or group counseling to assist with social, psychological, or medical problems which have been identified in the assessment process and included in the care plan.

Therapeutic counseling is essential for preventing some clients from being placed in a nursing facility (NF). This service may be utilized in situations where clients may face crises, severe anxiety, emotional exhaustion, personal loss/grief, confusion, and related problems. Counseling by licensed or certified counselors in conjunction with other services (e.g., respite, in-home support, meals) may reverse some states of confusion and greatly enhance the ability of a family to care for the client in the community, or allow the client to cope with increasing impairment or loss.

Money Management (8.5): this service assists the client with activities related to managing money and the effective handling of personal finances. Services may be either periodic or as full-time substitute payee. Services may be provided by organizations or individuals specializing in financial management or performing substitute payee functions.

Communications Services (9.1 and 9.2): clients who receive these services are those with special communication problems such as vision, hearing, or speech impairments and persons with physical impairments likely to result in a medical emergency. Services shall be provided by organizations such as:

- Speech and hearing clinics.
- Organizations serving blind individuals.
- Hospitals.
- Senior citizens centers.
- Providers specializing in language translation and interpretation.
- Individual translators.
- Telephone companies or other providers specializing in communications equipment for disabled or at-risk persons.

Services shall be provided on a routine or emergency basis as designated in the client's plan of care.

Communication: Translation/Interpretation (9.1): the provision of translation and interpretive services for purposes of instruction, linkage with social or medical services, and conduct of business essential to maintaining independence and carrying out the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) functions.

Communication Device (9.2): the rental or purchase of 24-hour emergency assistance services, installation of a telephone, assistive devices for communication for clients who are at risk of injury or institutionalization due to physical conditions likely to result in a medical emergency. Monthly telephone charges are excluded from this category and are not permissible.

Purchase of emergency response systems is limited to those clients who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The record must document consideration of available options and that the client is able to understand and utilize the service and/or item being funded through Waiver Services.

The following are allowable:

1. Medic-alert type bracelets/pendants.
2. Intercoms.
3. Emergency response systems (Life-lines).
4. Wander-alerts.
5. Monitoring services and devices (baby monitor).
6. Light fixture adaptations (blinking lights, etc.).
7. Telephone adaptive devices not available from the telephone company or California Technology Assistance Project (CTAP).
8. Other electronic devices/services designed for monitoring or to summon emergency assistance.

Land line based telephone installation or reactivation of service will only be authorized to allow the use of telephone-based electronic response systems where the client has no telephone, or for the isolated client who has no telephone and who resides where the telephone is the only means of communicating health needs.

3.1500 Service Monitoring and Care Management Follow Up

3.1510 Recording Guidelines

Recording of monitoring and follow up activities is an integral part of care management activity. The documentation process includes obtaining and analyzing information, and incorporating the results of this analysis into plans for future action and follow up. It is important to capture the results of authorized services and any change in the client's situation that affects the care plan. The documentation should serve to clarify both the necessity and appropriateness of all services (Section 3.820, What Progress Notes Include).

3.1520 Monitoring Activities

The care manager serves as a resource manager who arranges for timely, effective, and efficient mobilization and allocation of services to meet the client's needs as defined by the care plan.

Care management monitoring and follow-up activities must occur at regular intervals that meet or exceed the following minimum parameters:

- Monthly contact – may occur by telephone or face-to-face.
- Quarterly home visit – face to face in the client's home (not to exceed 3 month intervals without justification).
- Annual reassessments – face to face in the client's home.
- LOC recertification – face to face or by record review (not to exceed 365 days from prior LOC).
- Annual alternate discipline visit – face to face visit in the client's home. This visit may be conducted as a monthly contact home visit, Quarterly visit, or Reassessment, but should be within 12 month intervals. If the site conducts the alternate discipline visit at the reassessment, it is acceptable to take advantage of the one month grace period.

Monitoring includes review of the client's status which encompasses, but is not limited to, addressing each problem statement identified on the care plan. Monitoring captures the care management activities which are then documented in the written record.

The content of follow up activities should include:

- counseling and education of the client's family and other informal support persons so that services provided by the informal support network can continue at the existing or an increased level;
- counseling the client to utilize services more effectively;
- and/or interdisciplinary collaboration and crisis intervention as needed.

Follow-up activities also encompass service coordination activities such as:

- Acquisition and/or implementation of services through purchase or referral as specified in the client's care plan.
- Coordination of services and support programs.
- Collection and distribution of information.
- Measurement of progress toward the goals stated in the care plan.
- Monitoring implementation of the plan to ascertain that goals have been met.
- Revision of the care plan as necessary.

3.1530 (Section Changed to 3.030)

3.1600 (Section Changed to 3.040)

3.1700 Termination

The case record must contain documentation of the relevant actions and decisions leading up to the termination of a client's participation in MSSP. Termination plans must include how services will be provided after the client leaves MSSP, except for reason codes 1, 7 and 10.

Rescission of Termination: A former MSSP Client can be reinstated into the program without completing a reenrollment packet if they return within 30 days of the termination date. The site shall determine if a complete initial assessment is needed or if a reassessment will suffice for reinstatement. The rationale and justification for electing to complete an initial assessment or reassessment must be documented in the progress notes and the care plan revised accordingly.

3.1710 Termination Reason Codes

Termination actions are reported into the program's data system by completing the Termination section of the Client Enrollment/Termination Form (CETIF; Appendix 17).

Clients may be terminated from MSSP for any one of the reasons coded as follows:

1. Death.

2. Moved out of the area.

3. No longer desires services.

4. Other.

5. No longer certifiable for placement in a nursing facility.

6. No longer Medi-Cal eligible.

7. Institutionalization.

8. High Cost: service costs exceed or are expected to exceed 120% of the site's "benchmark" for more than three consecutive months, and continued services cannot be justified according to the criteria listed in Section 3.930 (3d) Authorization and Utilization of Services.

9. No longer MSSP/Medi-Cal eligible. May still be eligible for Medi-Cal, but no longer with an aid code that qualifies for MSSP; including unable to meet share of cost requirement through In-Home Supportive Services.

10. Unable/unwilling to follow the care plan; unable/unwilling to utilize care management effectively.

3.1720 Notice of Action

State law and Medi-Cal regulations require a Notice of Action (NOA) to be sent to an applicant who is denied eligibility at point of application (Appendix 2; Section 3.230 Referrals not Accepted for MSSP Participation, and 3.310 Non-enrolled Persons) or for an adverse decision regarding a reduction, suspension, termination or denial of waiver services (Appendix 4; Section 3.640.8 Changes to the Care Plan), or to a MSSP client who is terminated from the program for the following reason codes: 2, 3, 4, 5, 7, 8, 9 or 10 (Appendix 2, Section 3.1710 Termination Reason Codes).

Timeframes required for mailing NOA's are specified in Chapter 6, Section 6.400.

The NOA informs the applicant/client of rights to a fair hearing if they are dissatisfied with the termination action, change in services, or denial of entry into the MSSP (Chapter 6, Client Rights). A copy of the NOA must be filed in the case record.

Note: If a site is using NOAs to documentation additions to the care plan (optional), a copy of each NOA must be filed in the case record.

3.1730 Re-enrollment

Unless the re-enrollment is as a result of a rescission of termination (Section 3.1700, Termination) whenever a client re-enrolls in MSSP, the following forms must be completed and retained in the client file:

- Application
- AUDPHI's
- LOC Certification
- Initial Health Assessment (Appendix 18)
    - Cover Sheet
    - Body of the Assessment
    - Medication List
    - Problem List
    - IHA Summary
- Initial Psychosocial Assessment (Appendix 19)
    - Cover Sheet
    - Body of Assessment
    - Psychological Functioning
    - Site's cognitive screening tool (Appendix 19f)
    - Functional Needs Assessment Grid (Appendix 19d)
    - Problem List
    - IPSA Summary
- Care Plan

Note: The re-enrollment date will be the client's new anniversary date. The client's original MSSP number will be reactivated and reassigned to them (Section 7.560, MSSP Client Codes).

3.1800 Transfer of Clients Between Sites

When a client of one MSSP site relocates to an area served by another MSSP site, management services can continue at the new site, but only if the new site has an available vacancy. To facilitate this transition, the sending site and the receiving site must work together and coordinate the transfer.

3.1810 Responsibilities of the Sending Site

The Site should:

- Prepare the client to expect that services may be different. There is no guarantee that services they received at one site will be replicated at another.

- Contact the receiving site early in the process to facilitate enrollment.

- Obtain a signed release from the client to provide copies of pertinent case documents (e.g., current assessment, care plan, recent progress

notes) to the receiving site. If there are documents from other sources (recent discharge summaries, report from a treating physician, etc.), the sending site should obtain releases so that this information can be forwarded to the receiving site.

3.1820 Responsibilities of the Receiving Site

The Site should:

- Facilitate the enrollment process to coordinate with the client's moving plans.

- After the client has moved to their new home, complete the enrollment process with a new application, release forms, etc. The receiving site must follow the MSSP re-enrollment process for the transitioning client (Section 3.1730 Re-enrollment) but will assign a new MSSP number.

3.1830 Coordinate Billing

Only one site can bill for an individual client in any given month. The sending and receiving sites will need to agree on the last month to be billed by the sending site and the first month to be billed by the receiving site.